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ABSTRACT

Widowhood must be regarded as an expected stage in the life cycle of most women and some men. Widowed individuals endure much emotional and physical distress, often in conjunction with financial hardship and relative social isolation. Conceptual and practical guidelines for use by professionals in the fields of gerontology and mental health are needed to prevent the stresses of widowhood. A content analysis of recommendations from 118 widows concerning preparation for widowhood yielded four major areas of concern: financial preparation, development of independence, specific planning for widowhood, and emotional preparation. These recommendations, examined within the context of several theories, suggest the strategies of community education, social action, and counseling as helpful in preparing for widowhood. The goal of these strategies should be to develop intervention methods that maximize the future potential of the widowed partner, while respecting the potential for growth by both partners. Gerontology professionals are in a unique position to be able to foster community awareness and influence the health of the current and future elderly.
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Strategies for Preventing the Stresses of Widowhood

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Running Head: Preventing the Stresses of Widowhood

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The Need for Prevention

Widowhood produces casualties. Widowed individuals -- of both sexes -- die sooner than their married counterparts (Kraus & Lilienfeld, 1959). The survivors endure a disproportionate amount of emotional and physical distress, often in conjunction with financial hardship and relative social isolation (C. J. Barrett, 1977b). It is not feasible to prevent the occurrence of widowhood. (The view that divorce will prevent it is fallacious, since most divorced persons remarry.) Women could reduce dramatically the length of time they spend as widows -- which currently averages 18½ years for those who do not remarry (Carter & Glick, 1970) -- by consistently choosing husbands eight years their juniors. Barring a major change in death rates or norms for mate selection, we must regard widowhood as an expected stage in the life cycle of most women -- and some men. With a psycho-social event so predictable, with an outcome so consistently tragic, we must swallow our professional shame for ignoring it and move toward solutions.

In the last several years, individual and group treatment modalities have been explored with widowed individuals (C. J. Barrett, 1978; Silverman, MacKenzie, Pettipas, & Wilson, 1974; Hiltz, 1977). Organized programs of services for the widowed now number about 150 in the United States and Canada (Loewinsohn, 1977). These approaches are both laudatory and necessary. But

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how many times must we re-learn the lessons of community mental health? We must begin to tackle major social problems from the vantage point of prevention rather than cure. This article will develop conceptual and practical guidelines for use by professionals in the fields of gerontology and mental health who wish to prevent the waste of human resources in widowhood.

The Parameters of Preparation

We may safely assume that a very low level of preparation for widowhood currently prevails in our culture. Seventy-one percent of a large sample of married men who died before the age of 65 did not even leave wills (Nuckols, 1973). Is there any evidence indicating that preparation does in fact help? Most studies posing this question have looked at one of two variables: the length of the fatal illness itself, or the existence of negative psychological reactions (such as depression) prior to the death which have been conceptualized as anticipatory grief. The data do not consistently support the hypothesis that advance warning -- or advance grief -- make life easier for the survivor (Rees, 1971; Clayton et al., 1972; Blanchard, 1976; Silverman, 1974; Clayton et al., 1968; Clayton et al., 1971; Carey, 1977; Clayton et al., 1973; Gerber et al., 1975; Schwab et al., 1975; Parkes, 1975; Sheskin & Wallace, 1976; Barrett & Becker, 1978). Sheskin & Wallace (1976) and Gerber (1974) outline some specific social consequences of anticipation of the death that may mediate its ultimate positive or negative effect on the bereaved. Anticipatory processes may vary with the cause of death, particularly in the case of war deaths (Barinbaum, 1976; Eliot, 1946) and suicide (Wallace, 1973; Bunch, 1972; Cain & Fast, 1966).

As an alternative empirical approach, I asked 118 widows directly about their preparation -- whether they had ever thought about the possibility of

being widowed, whether they had expected to be widowed, and whether they had particular ideas about what they would do if they were widowed. The answers to these questions were summed to derive a measure of the extent of preparation. When this variable was examined in relation to twelve different measures of psychological adjustment in widowhood, not a single significant relationship was discovered (Barrett & Becker, 1978). However, a number of social and demographic variables did predict the extent of preparation. Those widows who as wives had widowed friends scored higher in preparation. The "best" prepared were the widows of men who died of long illnesses. Those living alone as widows reported greater preparation than those who live with children or others. Surprisingly, the widow's age had no bearing on her preparation. Nor were widows from long marriages better prepared than those from short ones. Paid employment while married was not associated with increments in preparation, nor was marital happiness -- or unhappiness (Barrett & Becker, 1978).

If the extent of preparation which normally evolves is insufficient to make a real difference in the months following the death of one's spouse, might we not consider more deliberate planning for this stage of life? Might not individuals who have experienced widowhood have some particularly insightful suggestions?

The Recommendations of Widows

Recommendations were elicited from the same sample of 118 women. They were Los Angeles County residents who attended an orientation meeting prior to assignment to a seven-week therapeutic widows' group (C. J. Barrett, 1978). They ranged in age from 29 to 78, with a mean of 55. The length of their widowhood ranged from one month to 30 years, with a mean of five years.

They were asked to answer in writing this question: "Is there anything you think women should know or do before they are widowed?" Ninety-four widows responded, although 12% of these respondents specifically wrote that they had no advice.

A content analysis of the respondents' answers yielded four major areas of concern. The most frequent theme was financial preparation; it was recommended by 50% of the respondents. Suggestions included knowledge of the family business (N=43), financial management in general (N=12), and the location of important papers in particular (N=9), keeping up-to-date financial records (N=7) and having adequate insurance (N=10), a will (N=8) and knowledge of income tax regulations (N=), and the establishment of independent credit ratings (N=3).

The second most frequent theme was the development of independence, recommended by 40% of the respondents. They advised women to develop independent skills (N=19) and to be independent in their marriages (N=19). Several advocated additional education (N=3) or participation in organizations (N=1).

The third theme was specific planning for widowhood, expressed by 30% of the respondents. These widows urged women to plan ahead (N=18), to talk with their husbands (N=14) and to find an advisor prior to widowhood (N=11). Several specifically encouraged the development of an advisor from among family associates or relatives (N=4).

The final theme, which appeared in the recommendations of 17% of these widows, was explicit emotional preparation. Some advised women to know and understand possible emotional reactions to bereavement (N=9). Others urged women to appreciate their husbands and/or to live life to the fullest while married (N=7).

Theoretical Implications

Let us examine how these recommendations fit within the context of several theories. Caplan (1964) outlined three levels of preventive intervention. Some providers of services to widowed persons conceptualize crisis intervention in the first weeks of widowhood as primary prevention (e.g., Gerber, 1969; Williams, Polak, & Vollman, 1972; McCourt, Barnett, Brennen, & Becker, 1976). Either this is a misnomer, or else these widows have recommended something more primary than primary prevention. Their recommendations include both cognitive and affective preparation and the securing of tangible resources -- both monetary and human -- to help meet the anticipated crisis.

Emerging life-span developmental theory (Goulet & Baltes, 1970) may eventually encompass life-planning behavior of the type envisioned in retrospect by these widows, particularly as we gain more understanding of the ways in which alternatives at one life stage impact on subsequent stages. Lopata has effectively applied social role theory to the study of both housewives (Lopata, 1971) and widows (Lopata, 1973). Some of the widows in this research were undoubtedly aware that their roles as wives shaped the boundaries of their roles as widowed women.

Although the subjects in this research cannot be considered feminists, their suggestions are relevant to feminist theory. Their recommendations might be interpreted as admonishment to women to develop economic power and personal autonomy. From the perspective of behavior theory, these recommendations appear to identify some gaps in the typical behavioral repertoires of women that are critical to effective lives as single persons.

Psychodynamic theory has addressed the impact of loss of a loved object, but the concept of preparation for such loss has not been adequately explored. To the skeptic who challenges the very concept of preparation for loss, Eliot's (1946) remarks may be persuasive:

The real show is very different from even a dress rehearsal,
but it is also very different from what it would have been if
it hadn't been rehearsed.

A useful analogy exists in the psychology of illness field, with research documenting recovery advantages for patients who were explicitly prepared for major surgery (Egbert, Battit, Welch, & Bartlett, 1964; Janis, 1971). Another lies in the literature on preparation for the role loss that occurs in retirement.

Strategies for Implementation

There are at least three major professional tools which may be used to facilitate preparation for widowhood. The strategies of community education, social action, and counseling can address the recommendations of widows described here. These strategies may be implemented through diverse organizational auspices; including schools, the media, business, labor unions, hospitals, public and private agencies, churches, and women's and men's service organizations.

Community education about widowhood can take place through the utilization of the mass media, formal classes, consultation, workshops and community lectures. It should be incorporated into death education programs and should be geared to reach the public at all ages, including children. Planning for bereavement should include economic, legal, psychological and social factors (Kalish, 1977) -- the same arenas in which stresses typically occur, and which appear in the recommendations of these widows.

Janis (1971) recommends a three-step process of emotional inoculation in preparing individuals for stress. The first is provision of realistic information to make the person aware of his or her vulnerability. Once anticipatory emotions are aroused, the next step is a process of counter-acting feelings of helplessness, hopelessness or demoralization. The third step is to encourage the person to work out specific plans for protection.

Community involvement in social action on behalf of widowed persons can generate access to information and facilitate preparation indirectly. Such activity might include deliberate advocacy in the political arena (e.g., lobbying for legislation to reform Social Security regulations or to establish Displaced Homemakers Services) as well as action aimed at local social institutions and industries (e.g., banking, housing, employment and recreation).

Vocational counseling for junior high age girls should deal with the reality of widowhood (Cooperman, 1971). Psychological counseling strategies may be implemented not only with families where a terminal illness has been diagnosed (Adler, Balser, Cole, Johnston & Krant, 1975) but wherever future goals are an integral part of the family's concerns. Optimally, bereavement issues would be addressed routinely in pre-marital couples' counseling.

Illustrations from Professional Experience

As a university-based community psychologist, I have developed experience with some of these preventive intervention strategies. I have taught both credit and continuing education courses on widowhood, and have given continuing education workshops on widowhood for service providers including psychotherapists, nurses, chiropractors and nursing home administrators. I have also used television, radio and newspaper media to enhance public education, and have provided workshops, retreats or classes through churches, the Y. W. C. A. and women's organizations. In most of these settings, the

audience ranges widely in age, and includes both potential and actual widowed persons. I have found it useful to present information derived from needs assessment research in the local community (C. J. Barrett, 1976 & 1977a).

I often address the needs of the widowed, the concerns of the not-yet-widowed, and the potential roles of friends and relatives of the widowed in the same session. My experience indicates that the presence of these diverse groups can be very facilitative in helping all concerned to achieve a new and integrated perspective on the issues (C. J. Barrett, 1978b).

As a further illustration, a widowed facilitator for a church group of young married women presented explicit information on grief and then had these young wives invite their husbands to a joint meeting to discuss the eventuality of widowhood. A written anonymous evaluation documented that the experience was considered beneficial and led to appropriate planning by the couples, several of whom suggested multiple sessions for future groups (G. L. Barrett, 1978). Other educators are developing programs for older couples to prepare them for widowhood (Teitelman, 1978).

Conclusion

We do not yet know what particular advice widowers might have for their married male friends. Nor do we know what impact the particular strategies outlined here will have on marital relationships or on the spouses of those whose preparation for widowhood is increasing. Research is needed to assess this impact, as well as to ascertain the long-range effectiveness and optimal timing of various preventive strategies. Our goal should be to develop intervention methods that maximize the future potential of the widowed partner, while respecting the potential for growth by both partners in the here-and-now. A recurring assumption in the field of death and dying is that psychological advantages accrue to individuals who confront the likelihood of their own deaths. Thus both partners may profit from planning for a future

in which one of them will not be present. An explicit focus on prevention may also enhance the help available to the widowed. In an aware community, a natural support network for widowed persons may evolve, as individuals realize that "It might be my spouse who needs help -- it might even be me." Professionals in the field of gerontology are in a unique position to be able to foster such community awareness and thereby influence the ultimate health of both the current and future elderly.

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